

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 03/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/24/2011
NAME OF PROVIDER OR SUPPLIER DONELSON PLACE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2733 MCCAMPBELL ROAD NASHVILLE, TN 37214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Complaint investigation numbers 27046, 27370, were completed during the annual Recertification survey at Donelson Place Care and Rehabilitation Center, on March 24, 2011. No deficiencies were cited under 42 CFR PART 483.13, Requirements for Long Term Care for the complaints.	F 000	Donelson Place Care & Rehabilitation Center ("Facility") does not believe and does not admit that any deficiencies existed, before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation, or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its responses as part of its ongoing efforts to provide quality of care to residents.		
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's	F 159	The Business Office Manager will notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611 (a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other non-exempt resources reaches the SSI resource limit for one person the resident may lose eligibility for Medicaid or SSI. Corrective action for resident affected: Resident #4 and responsible party were notified, via letter, from the Business Office Manager on March 23, 2011, of reaching the \$200 threshold of the resource limit.	3/23/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kerry B. Davis

Administrator

4/8/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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2733 MCCAMPBELL ROAD
NASHVILLE, TN 37214

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F 159	<p>Continued From page 1 behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the resident trust accounts and interview, the facility failed to notify the resident or the resident's responsible party when the resident's trust account was within \$200.00 of the SSI (Social Security Income) resource limit (\$2000.00) for one (#4) of sixty-one resident trust accounts reviewed.</p> <p>The findings included:</p> <p>Review of resident #4's trust account revealed December 3, 2010, balance \$3179.44; January 3, 2011, balance \$3250.44; February 3, 2011, balance of \$1921.69.</p> <p>Interview with the Business Office Manager on</p>	F 159	<p>Other residents having the potential to be affected and corrective action: Business Office Manager conducted a 100% Resident Fund Management Service (RFMS) system audit on March 23, 2011, and other residents identified as being within the limits were sent Notification letters on March 23, 2011.</p> <p>On March 23, 2011, Administrator reviewed with Business Office personnel, the management of resident funds, including notification to residents when thresholds are reached.</p> <p>Measures to ensure practice does not recur: RFMS audits will be conducted monthly by business office personnel to ensure practice does not recur.</p> <p>This corrective action will be monitored by: The Business Office Manager will monitor monthly to ensure audits are conducted and that notifications are sent to residents and/or responsible parties regarding resource limits. Results of monthly audit will be reviewed by Administrator.</p>	

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F 159	Continued From page 2 March 23, 2011, at 1:20 p.m., in the conference room, confirmed the resident or the resident's responsible party had not been notified when the resident's trust account was within \$200.00, of SSI resource limit.	F 159			
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete a bladder assessment and develop an individualized toileting plan for two residents (#8, #6) of twenty-five residents reviewed.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on December 20, 2010, with diagnoses including Asthma, Diabetes Mellitus, and Urinary incontinence. Continued medical record review of the resident's Minimum Data Set (MDS) dated December 27, 2010, revealed no limitations on making self understood, no limitations on</p>	F 315	<p>F315 POC for those residents found to have been affected: By 3/31/2011, Residents #8 & #6 had 3-day bowel and bladder activity data collected for analysis. Evaluation of elimination patterns was conducted and an individualized bowel and bladder program was care planned and implemented by 4/6/2011, by Restorative Manager.</p> <p>Corrective actions for residents affected: All residents admitted, re-admitted and those experiencing changes in elimination status have the potential to be affected.</p> <p>All residents were audited by MDS Coordinator to evaluate the completeness and effectiveness of their current bowel and bladder programs based on a 3-day data collection document. Changes were made to the resident bowel and bladder programs as appropriately indicated by IDT (Interdisciplinary Team)</p> <p>Measures to prevent reoccurrence: (1)DON Re-educated the Admissions Nurse regarding initiating the 3-day elimination collection tool and communicating documentation requirements to staff was conducted on 4/6/2011. (2)Effective 4/11/2011, all new or re-admissions will have the 3-day elimination data collection tool, evaluation of data tool and individualized bowel & bladder program verified as present and accurate by MDS staff within 24 hours of admission. (3)Effective 4/11/2011 the Restorative Program Coordinator will implement a 3-day elimination data collection tool, evaluate the patterns and develop/implement an individualized bowel & bladder program for all residents with changes to their elimination status, within 24 hours of status change determination. (4)A document was created on 3/23/2011 to facilitate development of a documented, individualized bowel</p>	5/1/11	

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F 315	<p>Continued From page 3</p> <p>understanding others and was frequently incontinent of urine.</p> <p>Medical record review of the resident's Bladder Evaluation dated December 31, 2010, revealed the evaluation had not been completed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 in the facility conference room on March 23, 2011, at 9:35 a.m., confirmed the Bladder Evaluation had not been completed and an individualized toileting program had not been developed.</p> <p>Resident #6 was admitted to the facility on March 17, 2011, with diagnoses including Subacute Pelvic Fracture and Peripheral Vascular Disease.</p> <p>Medical record review of the History and Physical dated March 3, 2011; (at the time of admission to hospital prior admission to this facility) revealed resident #6 was "living independently" with a family member.</p> <p>Medical record review of the Data Collection Baseline Elimination (3 day data collection tool for determination of patterns) revealed 68 of 72 opportunities to document continence or incontinence data were incomplete. The documentation did not indicate if the 4 entries were episodes of bowel or bladder incontinence.</p> <p>Medical record review of the Daily Skilled Nurse's Notes from March 17-23, 2011, revealed the resident was incontinent of bladder and briefs were used.</p> <p>Interview with the resident on March 23, 2011, at</p>	F 315	<p>and bladder program utilizing analyzed data from the 3-day elimination record.</p> <p>(5) A mandatory in-service with all CNAs will be conducted by DON, on 4/7/2011 and 4/8/2011 regarding accurate and complete documentation requirements.</p> <p>(6) DON Re-educated the Restorative Program Coordinator regarding documentation and the components of a bowel and bladder program as well as the requirement for management and oversight of staff was conducted on 3/25/2011.</p> <p>Monitoring of Corrective Action:</p> <p>(1) A monthly audit for presence of an acceptable individualized bowel and bladder program based upon accurate and complete 3-day elimination records will be conducted by MDS for all residents admitted and experiencing changes in elimination. This data will be reported to the QA/PI Committee monthly ongoing. Analysis will include trends and recommended intervention to assure 100% compliance.</p> <p>(2) DON will track any trended error rates and staff will be individually approached for performance improvement or further education as necessary. Data will reflect 100% compliance by 5/1/2011.</p>		

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F 315	Continued From page 4 9:35 a.m., in the resident room, revealed the resident was able to identify the need and urge of to go to the toilet. Interview with the Certified Nursing Assistant (CNA #1) assigned to care for resident #6 in the hallway on March 22, 2011, at 3:33 p.m., revealed "sometimes" the resident was continent when checked. Interview in the day room of the 200 Hall with the Restorative Nurse (assigned the responsibility of Bladder and Bowel assessment) on March 23, 2011, at 3:50 p.m., verified resident #6 was not assessed for a baseline of bowel and bladder functioning and confirmed the facility failed to develop a personalized bladder and bowel plan for the resident.	F 315		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	F441 POC for those residents found to have been affected: Wound care nurse #1 was re-educated by the DON regarding proper gloving technique. The Staff Development Coordinator observed gloving technique on 5 occasions by 4/8/2011, and the wound care nurse #1 was found to be in compliance. Resident #13's daytime Foley leg bag is now stored in a sealed container under her bed, accessible to the staff when they need to store it as they need to store it as they prepare her for bedtime and is therefore no longer stored in shared space. Corrective Actions for residents affected: The Infection Control Program affects all residents. All residents with indwelling catheters were assessed and staff providing care were observed to verify 100% compliance with infection control protocol and measures. No concerns were noted. Measures to prevent reoccurrence: (1) CNA staff and licensed nursing staff will be in-serviced by the DON, on April 7, 8, 13th and 14th regarding the Infection Control Program, specifically	5/6/11

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F 441	<p>Continued From page 5</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to change gloves between clean and dirty environments for one (#2); and failed to store a urinary device in a manner to prevent spread of infection for one (#13) of twenty-five residents reviewed.</p> <p>The findings included:</p> <p>Observation on March 23, 2011, at 2:30 p.m., revealed Wound Care Nurse (WCN #1) gathered supplies and entered the room for resident #2. Continued observation revealed resident #2 was in the left side-lying position. Observation revealed liquid fecal material on the buttocks. Observation revealed the WCN #1 with gloved hands began the process of cleaning the fecal material with a wet washcloth. The WCN #1</p>	F 441	<p>focusing upon methods and behaviors to reduce the likelihood and/or prevent the spread of infection.</p> <p>(2) All staff is scheduled to complete Infection Control modules in the electronic education system (MedComm) by May 6, 2011.</p> <p>The two ADON's responsible for both (all) resident care units were re-educated by the DON, on April 1 and on April 8, regarding the Infection Control Program and their responsibilities pertaining to managing staff compliance, identification of and protocol for infections, isolation, standard precautions, hand washing and gloving technique, exposure control and managing resident compliance.</p> <p>Monitoring of Corrective Action: (1) The MedComm module record of completion and re-education documents will be placed in the personnel file. The in-service records will be maintained in the facility education binder.</p> <p>The Staff Development Coordinator will verify 100% with staff compliance with these activities.</p> <p>(2) Effective April 11, 2011 hand washing and gloving technique observations will be randomly conducted monthly by the Staff Development Coordinator.</p> <p>A sample, size no less than 10 observations each, will be conducted every month.</p> <p>Compliance rate will be calculated and presented monthly to the QA/PI Committee. 100% compliance will be demonstrated by May 6, 2011.</p>	

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F 441	<p>Continued From page 6</p> <p>wiped the material; folded the washcloth and continued to clean the resident's bottom. Observation revealed the WCN #1 repeated the process with additional washcloths until the bottom was clean. Continued observation revealed the WCN #1 without changing gloves pulled the covers over the resident's legs and bottom before leaving the bedside. Continued observation revealed the WCN #1 entered the bathroom; removed the gloves and washed the hands.</p> <p>Interview on March 23, 2011, at 2:52 p.m., with the WCN #1 outside the resident's room, confirmed the contaminated gloves were not changed prior to handling the bed linens.</p> <p>Observation of the bathroom between room #205 and #207 on March 22, 2011, at 10:12 a.m., revealed a urinary catheter collection bag and tubing draped across the handrail beside the commode.</p> <p>Interview in the bathroom on March 22, 2011, at 10:15 a.m., with Licensed Practical Nurse (LPN #1) revealed the urinary catheter belonged to one of the residents and verified the urinary device was not stored in a manner to protect other residents from exposure to possible infection.</p> <p>Medical record review revealed a physician order dated February 11, 2010, for resident #13 to use leg bag during the daytime and to use a regular drainage bag at night.</p> <p>Interview with LPN #1 on March 23, 2011, at 8:22 a.m., verified resident #19 uses the same bathroom as resident #13; and verified one</p>	F 441		

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F 441	Continued From page 7 resident in the adjoining room uses the bathroom with assistance. Interview with the Assistant Director of Nursing at the 100 hall nursing station on March 23, 2011, at 9:02 a.m., confirmed the facility failed to store the urinary device in a manner to protect other residents from spread of infection.	F 441			
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to obtain laboratory services for one (#12) of twenty-five residents reviewed. The findings included: Resident #12 was admitted to the facility on November 18, 2010, with diagnoses including Peripheral Arterial Disease, History of Cerebrovascular Accident, Bilateral Above the Knee Amputation, and Chronic Pain. Medical record review of a physician's order dated March 8, 2011, revealed the resident's Coumadin (blood thinner) was increased to 6.5 mg (milligrams) by mouth, each night. Continued review of the physician's order dated March 8, 2011, revealed a PT/INR (laboratory test to monitor blood clotting time) was to be obtained on	F 502	<p>F502 POC for those residents found to have been affected: The resident reviewed (#12) had the PT/INR originally ordered for 3/12/2011 obtained on 3/22/2011. The value was appropriately in range and no adverse effect was determined to have occurred.</p> <p>Corrective Actions for residents affected: All residents with orders for laboratory services have the potential to be affected.</p> <p>All residents receiving anti-coagulation therapy requiring PT/INR monitoring were audited to ensure 100% compliance with physician orders. No concerns were noted.</p> <p>Measures to prevent reoccurrence: (1) The ADON's, Staff Development Coordinator, Wound Care Nurses and Restorative Manager were deemed competent by Medline Representative to obtain point of service PT/INR values utilizing a mobile point of service device.</p> <p>By May 1, 2011 the PT/INR specimens will be obtained by facility staff on site. (2) On-site access to and in-servicing for the sub- contracted lab resulting site was provided by a laboratory representative by March 31, 2011 for immediate ability to obtain results. (3) The HIM Coordinators will be in-serviced, trained and deemed competent by the Staff Development Coordinator by April 25, 2011, to maintain the laboratory log and implement the laboratory specimen management system. (4) The laboratory specimen procurement and management processes were re-evaluated for effectiveness and quality by IDT on 3/30/2011. By</p>		5/1/11

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F 502	<p>Continued From page 8 March 12, 2011.</p> <p>Medical record review revealed no documentation the PT/INR had been completed on March 12, 2011.</p> <p>Medical record review of a physician's order dated March 21, 2011, revealed "...Please redraw PT/INR on 3/22/11..."</p> <p>Medical record review of a laboratory report dated March 22, 2011, revealed the PT was 21.6 (reference range 12.4-14.6) and the INR was 1.8 (reference range 2.0-3.5).</p> <p>Observation on March 22, 2011, at 1:50 p.m., revealed the resident lying on the bed watching television.</p> <p>Interview on March 22, 2011, at 3:10 p.m., with the Assistant Director of Nursing, at the nursing station, revealed the ADON had noted on March 21, 2011, the PT/INR was not done as ordered on March 12, 2011. Continued interview revealed the Nurse Practitioner was notified the PT/INR had not been obtained on March 12, 2011, and an order was received to obtain a PT/INR on March 22, 2011.</p>	F 502	<p>April 25, 2011, modifications and education/training will be completed by DON, clarifying responsible persons and establishing the lab specimen resulting document and communication flow.</p> <p>(5) In-servicing for re-education was conducted by DON regarding expectations for floor nurses specific to 24 hour chart check task, lab requisition completion, rounding process with the laboratory technician and medical record documentation will be provided April 12th and 13th, 2011.</p> <p>Monitoring of Corrective Action: The quality and timeliness of laboratory services will be audited monthly with the analysis of results and determined recommendations reported to the QA/PI Committee.</p> <p>The Admission Nurse, or DON designee will perform a 10% sample size audit monthly of all laboratory tests ordered with the threshold for compliance 100%.</p>		